RFS #10-40
ATTACHMENT E
PROGRAM DESCRIPTIONS AND COVERED BENEFITS

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1.0 Overview of the Programs

Medicaid is a federal-and state-funded health care program providing reimbursement for reasonable and necessary medical care for persons meeting eligibility requirements. The Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP), authorized by federally-approved section 1915(b) and 1115 waivers, administers the Hoosier Healthwise and the Healthy Indiana Plan (HIP) programs in Indiana. More detailed information about Indiana Health Coverage Programs (IHCP) is available on the State's website at http://www.indianamedicaid.com/.

2.0 Eligible and Excluded Populations

The State has sole authority for determining whether individuals or families meet any of the eligibility criteria of the Hoosier Healthwise and HIP programs. The FSSA Division of Family Resources (DFR) makes eligibility determinations.

2.1 Hoosier Healthwise

Enrollment in managed care is mandatory for Medicaid individuals in the children, pregnant women and low-income families aid categories. It is also mandatory for children eligible for CHIP and presumptively eligible pregnant women. The specific eligibility aid category determines the benefit package.

The following Medicaid enrollees are excluded from participation in Hoosier Healthwise managed care:

- Persons in nursing homes and other institutions, such as ICF/MR and PRTF facilities
- Undocumented persons
- Persons receiving waiver or hospice services
- Persons who have spend-down
- Wards and foster children
- Children receiving adoption assistance
- The MA-U population

2.2 Healthy Indiana Plan

The Healthy Indiana Plan (HIP) is a Medicaid expansion for individuals 19-64 years of age with annual household income of not more than 200% of the federal poverty level (FPL). All individuals eligible for HIP must enroll in managed care, with the exception of certain high-risk individuals in the Enhanced Services Plan (ESP), which is managed by the Indiana Comprehensive Health Insurance Association (ICHIA).

Individuals must be uninsured for at least six (6) months to participate in HIP. Additional eligibility criteria are set forth in IC 12-15-44 and 405 IAC 9-4. The following individuals are not eligible for HIP:

- An individual who participates in the federal Medicare program
- An individual who qualifies for Medicaid under another aid category
- An individual who has access to an employer-sponsored health plan
- An individual who has health insurance

3.0 Delivery System

Managed care organizations (MCOs), which include both Indiana-licensed accident and sickness insurers and HMOs, contract with OMPP to provide covered services to Hoosier Healthwise and HIP enrolled members. The MCOs manage care through a contracted network of PMPs, specialists and other providers.

The State requires MCOs to initiate network development. The State will evaluate the Contractor's progress in its network development efforts prior to the start date of the Contract. OMPP reserves the right to limit the enrollment, by county, of a particular MCO, in order to ensure the members have adequate choice of plans.

4.0 Hoosier Healthwise Covered Services and Benefit Packages

The Hoosier Healthwise program encompasses four Benefit Packages described below.

4.1 Package A: Standard Coverage

Package A eligible members receive full Medicaid benefits. This package includes children, pregnant women and low-income families in Temporary Assistance for Needy Families (TANF), TANF-related and CHIP Phase I aid categories. CHIP Phase I includes children under age 19 whose family incomes are up to 150 percent of the FPL. Pregnant women who meet the TANF income and resource criteria receive Package A benefits. Eligibility redetermination is generally required every twelve (12) months. By state law (IC- 12-15-6-4), no co-payments or premiums are permitted.

4.2 Package B: Pregnancy Coverage and Pregnancy-Related Coverage

Package B benefits are designed for pregnant women whose income is below 200 percent of the FPL without regard to their resources. Package B benefits include pregnancy-related and postpartum care (including prenatal, delivery and postpartum services). Eligibility extends up to sixty (60) days postpartum. By state law (IC- 12-15-6-4), no co-payments or premiums are permitted.

Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care and family planning services.

Services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus, and all services that are pregnancy-related for an extended post-partum period. The post-partum period begins on the last day of pregnancy and extends through the end of the month in which the sixty (60) day period following termination of the pregnancy ends.

4.3 Package C: CHIP Phase II

Package C eligible members receive CHIP benefits that are similar to Medicaid benefits with some additional limitations. Package C includes preventive, primary and acute care services for children under age 19 whose family incomes are 150 to 250 percent of FPL.[1] Package C members are subject to copayment requirements and must be charged co-payments or other cost-sharing fees for MCO-covered services. Package C members, following 407 IAC 3-10-3 and 407 IAC 3-9-3, are required to pay co-payments for prescription drugs ($3.00 generic and $10.00 brand name), which are reimbursable by Indiana Medicaid fee-for-service (FFS) under the pharmacy benefit consolidation, and ambulance transportation ($10.00).

4.4 Package P: Presumptive Eligibility

Package P eligible members receive ambulatory prenatal services. A list of Package P covered services shall be published in the Indiana Administrative Code under 405 IAC 2-3.2-1 in 2010. Ambulatory prenatal care services are defined as outpatient services related to pregnancy, including prenatal care services and services related to other conditions that may complicate the pregnancy.

4.5 Hoosier Healthwise Benefits

Hoosier Healthwise covered benefits include CHIP-covered services and certain Medicaid covered services. Medicaid covered services are outlined in 405 IAC 5 and CHIP (Package C) covered services are outlined in 407 IAC 3. Table 1 provides a general summary of the Medicaid/CHIP covered services and limitations, identifies whether each service is reimbursed by the MCOs, and outlines under which benefit package each service is covered. Attachment D, Scope of Work and the Managed Care Policies and Procedures Manual describe the benefits and services in greater detail including, but not limited to, the following:

- Medicaid and CHIP services that are covered under Hoosier Healthwise.
- Self-referral services that include but are not limited to chiropractic, eye care, podiatric, family planning, HIV/AIDS targeted case management, emergency services and behavioral health services.
- Services "carved out" from the Contractor's responsibility are Individualized Education Plan services, Individualized Family Services Plan services, dental services, Medicaid Rehabilitation Option (MRO) services and pharmacy services reimbursable by Indiana Medicaid FFS under the pharmacy benefit consolidation.
- Medicaid services excluded from Hoosier Healthwise are those services that qualify for long-term level of care, i.e., nursing home, home-and community-based service (HCBS) waivers, and hospice, as well as PRTF services.
- Non-covered services are those services identified in 405 IAC 5 as being non-covered, including the list of non-covered services set forth in 405 IAC 5-29-1.

5.0 HIP Covered Services and Benefit Package

The HIP program covers the benefits set forth below. High-risk individuals enrolled in the ESP also receive enhanced disease management and case management services.

[1] The State anticipates expanding CHIP eligibility to 300 percent of the FPL in 2010.

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HIP covered benefits include physician services, behavioral health services, inpatient and outpatient care, emergency services, preventive care services, family planning services, hospice, pharmacy services, DME, diagnostic services and therapies, disease management and home health, as set forth in 405 IAC 9-7. The annual per person benefit maximum is $300,000. The lifetime per person benefit maximum is $1,000,000. Table 2 provides a general list of the HIP covered services and limitations and identifies whether each service is reimbursed by the MCOs. Attachment D, Scope of Work and the Managed Care Policies and Procedures Manual describe the benefits and services in greater detail including, but not limited to, the following:

- Services that are covered under HIP.
- Self-referral services that include but are not limited to family planning services, podiatric services, psychiatric services, diabetes self-management services, emergency services and behavioral health services.
- Services "carved out" from the Contractor's responsibility are pharmacy services reimbursed by Indiana Medicaid FFS under the pharmacy benefit consolidation.
- Medicaid services excluded from HIP are pregnancy services, long-term institutional care and Home and Community Based waiver services.
- Non-covered services are set forth in 405 IAC 9-7-13.

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Service[2]	Reimbursed by MCO[3]	Package A Standard Plan[4]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Case Management for Persons with HIV/AIDS	YES (Self-referral)	Targeted case management services limited to no more than 60 hours per quarter.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered service.
Case Management for Mentally Ill or Emotionally Disturbed (405 IAC 5-21)	NO	Targeted case management services limited to those provided by or under supervision of qualified mental health professionals who are employees of a provider agency (CMHC) approved by the Department of Mental Health.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Unless otherwise provided by IC 12-17.6-4-2, targeted case management services are covered subject to the same coverage policies and benefit limitations as apply to Package A.
Case Management for Pregnant Women** (405 IAC 5-11)	YES	Limited to one initial assessment, one reassessment per trimester and one postpartum assessment.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered service.

[2] In Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

[3] Services not reimbursed through Hoosier Healthwise are covered (available) and reimbursed for members under traditional Medicaid benefits reimbursement.

[4] Medicaid covered services and limitations in Packages A and B are cited in Title 405, Article 5 of the Indiana Administrative Code. Package C covered services and limitations are cited in Title 407, Article 3 of the Indiana Administrative Code. Indiana Administrative Code can be found on the State's website: http://www.state.in.us/legislative/iac.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Chiropractors* (405 IAC 5-12)	YES (Self-referral)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member per year.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 14 therapeutic physical medicine treatments per member per calendar year. An additional 36 treatments may be covered if prior approval is obtained based on medical necessity. There is a 50-treatment limit per calendar year.
Dental Services (405 IAC 5-14)	NO	In accordance with Federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A. Benefit limit $600 per year for ages 21 years and older.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	All medically necessary dental services are provided for children enrolled in Package C even if the service is not otherwise covered under CHIP.
Diabetes Self Management Training Services* (405 IAC 5-36)	YES	Limited to 16 units per member per year. Additional units may be prior authorized.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Limited to 16 units per member per year. Additional units may be prior authorized.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Drugs Prescribed (Legend) Drugs (405 IAC 5-24)	NO (with the exception of physician administered drugs)	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid.
Drugs -Over-the-counter (Non-legend)	NO	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available via a link from the IHCP programs website at http://www.indianamedicaid.com/ihcp/index.asp.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Not covered except for insulin.
Early Intervention Services (Early Periodic Screening, Diagnosis and Treatment [EPSDT]) (405 IAC 5-15)	YES	Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the HealthWatch EPSDT periodicity and screening schedule.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Covers immunizations, and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the Package C benefit package coverage limitations.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Emergency Services (IC 12-15-12-15 & -17)	YES (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.
Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)	YES (Self-referral)	Coverage for the initial vision care examination will be limited to one examination per year for a member under 19 years of age and one examination every two years for a recipient 19 years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age and one pair every two years for members 19 years and older.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Vision care examination is limited to one examination per year for a member under 19 years of age unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen or broken beyond repair.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Family Planning Services and Supplies	YES (with the exception of drugs and supplies listed in Section 5.4 of Attachment D as being reimbursed by FFS) (Self-referral)	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services. Family planning services are not available under Package P.	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no ongoing treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.
Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)	YES	Coverage is available for medically necessary services provided by licensed health care practitioners.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for medically necessary services provided by licensed health care practitioners.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	YES	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services Inpatient* (405 IAC 5-17)	YES	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	Inpatient services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services Outpatient* (405 IAC 5-17)	YES	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Hospice care** (405 IAC 5-34)	NO	Hospice is available under Medicaid if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. Member must be disenrolled from Hoosier Healthwise before hospice benefit can begin.	Non-covered services.	Non-covered services.
Laboratory and Radiology Services (405 IAC 5-18; 405 IAC 5-27)	YES	Services must be ordered by a physician.	Coverage is limited to services related to pregnancy, and conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a physician.
Long Term Acute Care Hospitalization	YES	Long term acute care services are covered. Prior authorization is required. An all inclusive per diem rate is paid based on level of care.	Long term acute care hospitalization services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Long term acute care services are covered up to 50 days per calendar year. Prior authorization is required. An all inclusive per diem rate is paid based on level of care.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)** (405 IAC 5-19)	YES (Except supplies identified in Section 5.2 of Attachment D as being reimbursed by FFS, dental devices, dental products and dental supplies)	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Covered when medically necessary. Maximum benefit of $2,000 per year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased depending on which is more cost-efficient.
Mental health/Behavioral health services-Inpatient (State Psychiatric Hospital)** (405 IAC 5-20-1)	NO	Covered for individuals under age 21 if in a certified wing.	Inpatient services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitations as apply to Package A.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Mental health/Behavioral health services-Inpatient (Free-standing Psychiatric Hospital, 16 beds or less)** (405 IAC 5-20)	YES	Covered.	Inpatient services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitations as apply to Package A.
Mental health/Behavioral health services-Inpatient (Free-standing Psychiatric Hospital, more than 16 beds such as institution for mental diseases)** (405 IAC 5-20)	YES	Covered for members under 21 years of age, or under 22 and begun inpatient psychiatric services immediately before his/her 21st birthday.	Inpatient services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Unless otherwise provided by IC 12-17.6-4-2, inpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitations as apply to Package A.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Mental health/ Behavioral health services-Outpatient (405 IAC 5-20-8)	YES, except MRO services	Coverage includes partial hospitalization services, Clinic Option services, mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. MCOs are responsible for Methadone treatment provided in a clinic setting.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services. MCOs are responsible for Methadone treatment provided in a clinic setting.	Unless otherwise provided by IC 12-17.6-4-2, outpatient mental health/substance abuse services are covered subject to the same coverage policies and benefit limitations as apply to Package A. MCOs are responsible for Methadone treatment provided in a clinic setting.
Medicaid Rehabilitation Option (MRO) -Community Mental Health Centers (405 IAC 5-21)	NO	Coverage includes outpatient mental health services, partial hospitalization (group activity program) and case management. The codes for MRO services are: H0031-HW; H0004-HW, -HS, -HR, or -HQ; H2011-HW; H0033-HW; H2014-HW; H0035-HW; T01016-HW or -TG; 97535-HW or -HQ; 97537 -HW or -HQ.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Unless otherwise provided by IC 12-17.6-4-2, MRO services are covered subject to the same coverage policies and benefit limitations as apply to Package A.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Mentally Retarded Services-Intermediate Care Facilities ** (405 IAC 5-13-2)	NO	60 days maximum, pending and prior to level of care determination. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services. Member must be disenrolled from Hoosier Healthwise for the benefit to begin.	Non-covered services.	Non-covered services.
Nurse-midwife services (405 IAC 5-22-3)	YES	Coverage is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners (405 IAC 5-22-4)	YES	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for medically necessary services or preventive health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.

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Nursing Facility Services (Long-term)** (405 IAC 5-31-1)	NO (responsible for up to 60 days while the level of care determination is pending)	Requires pre-admission screening for level of care determination and disenrollment from Hoosier Healthwise. Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation.	Non-covered services.	Non-covered services
Nursing Facility Services (Short-term) (405 IAC 5-31-1)	YES	The MCO may obtain services for its members in a nursing facility setting on a short-term basis, i.e., for fewer than 30 calendar days. This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The MCO can negotiate rates for reimbursing the nursing facilities for these short-term stays.	Nursing facility services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered services.
Occupational Therapy** (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Cannot exceed 12 hours, sessions or visits in 30 calendar days.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.

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Organ Transplants (405 IAC 5-3-13)	YES	Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.	Organ transplants available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered services.
Orthodontics**	NO	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.
Out-of-state Medical Services** (405 IAC 5-5)	YES (with the exception of pharmacy services)	Medicaid reimbursement is available for the following services provided outside Indiana: acute hospital care; physician services; behavioral health services, dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; and durable medical equipment and supplies. All out-of-state services are subject to the same limitations as in state services.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services. Only outpatient out-of-state services covered under Package P.	Covers acute, general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Coverage is subject to any limitations included in the CHIP benefit package.
Physicians' Surgical and Medical Services* (405 IAC 5-25)	YES	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 4 per month or 20 per year per member per provider without prior authorization.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services. Only outpatient physician surgical and medical services covered under Package P.	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per rolling 12-month period per member without prior authorization.

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Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Physical Therapy** (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Cannot exceed 12 hours, sessions or visits in 30 calendar days.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year, per type of therapy.
Podiatrists (405 IAC 5-26)	YES (Self-referral)	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. Routine foot care services are not covered.
Psychiatric Residential Treatment Facility (PRTF) (405 IAC 5-20-3.1)	NO (Member will be disenrolled from Hoosier Healthwise)	Reimbursement is available for medically necessary services provided to children younger than 21 years old in a PRTF. Reimbursement is also available for children younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. All services require prior authorization.	PRTF services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Unless otherwise provided by IC 12-17.6-4-2, psychiatric residential treatment services are covered subject to the same coverage policies and benefit limitations as apply to Package A.

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ATTACHMENT E
PROGRAM DESCRIPTIONS AND COVERED BENEFITS
Table 1. Hoosier Healthwise Benefits

Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Rehabilitative Unit Services - Inpatient** (405 IAC 5-32)	YES	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function or self-care activities.	Inpatient services available for Package B only. Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covered up to 50 calendar days per calendar year.
Respiratory Therapy* (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, emergency, and oxygen in a nursing facility, 30 calendar days following discharge from hospital when ordered by physician prior to discharge.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.
Rural Health Clinics (405 IAC 5-16-5)	YES	Coverage is available for services provided by a physician, physician assistant nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for services provided by a physician, physician assistant, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.
Smoking Cessation Services (405 IAC 5-37)	YES (with the exception of pharmacy services)	Reimbursement is available for, at minimum, eight counseling sessions per rolling 12 months, and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37)	Reimbursement is available for, at minimum, eight counseling sessions per rolling 12 months, and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37)	Reimbursement is available for, at minimum, eight counseling sessions per rolling 12 months, and 24 weeks of pharmacotherapy treatment per rolling 12 months. (Pending amendment to 405 IAC 5-37)

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ATTACHMENT E
PROGRAM DESCRIPTIONS AND COVERED BENEFITS
Table 1. Hoosier Healthwise Benefits

Service [1]	Reimbursed by MCO [2]	Package A Standard Plan [3]	Package B/Package P Pregnancy Coverage Only	Package C Children's Health Plan
Speech, Hearing and Language Disorders* (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by physician prior to discharge.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year, per type of therapy.
Transportation - Emergency* (405 IAC 5-30)	YES	Coverage has no limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge, subject to the prudent layperson standard.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Covers emergency ambulance transportation using the prudent layperson standard as defined in 407 IAC 1-1-6. $10 co-payment applies.
Transportation – Non-emergent (405 IAC 5-30)	YES	Non-emergency travel is available for up to 20 one-way trips of less than 50 miles per year without prior authorization.	Coverage is limited to services related to pregnancy, as well as conditions that may complicate the pregnancy or urgent care services.	Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician; $10 co-payment applies. Any other non-emergent transportation is not covered.

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ATTACHMENT E
PROGRAM DESCRIPTIONS AND COVERED BENEFITS
Table 2. HIP Benefits

Service Category	Benefit	Reimbursable by MCO?	Limitations/Co-pay	Subject to POWER Account Deductible?
Inpatient Facility	Medical/Surgical	Yes		Yes
	Mental Health/Substance Abuse (405 IAC 9-7-3)	Yes	Covered the same as physical illness	Yes
	Skilled Nursing Facility (405 IAC 9-7-2(a)(5))	Yes	Excludes custodial care; subject to a 60 day maximum	Yes
Outpatient Facility	Surgery	Yes		Yes
	Emergency Room (405 IAC 9-2-13 and 405 IAC 9-7-9)	Yes (self-referral)	Childless adults are subject to $25 co-payment. Parents are subject to co-payments according to the following schedule, unless the prudent layperson standard is met: • < 100% FPL - $3 • 100-150% FPL - $6 • 151-200% FPL - $25	Yes—POWER Account funds cannot be used to pay the ER co-pay
	Urgent Care	Yes		Yes

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS
Table 2. HIP Benefits

Service Category	Benefit	Reimbursable by MCO?	Limitations/Co-pay	Subject to POWER Account Deductible?
	Physical/Occupational/Speech Therapy	Yes	25 visit annual maximum for each therapy.	Yes
	Radiology/Pathology	Yes		Yes
	Diagnostic Services, including pregnancy testing (405 IAC 9-7-2(a)(7))	Yes		Yes
	Pharmacy and Blood	Yes		Yes
	Cardiovascular	Yes		Yes
	FQHC and RHC services	Yes		Yes
Professional Services	Inpatient/Outpatient Surgery	Yes		Yes
	Inpatient/Outpatient/ER Visits	Yes		Yes
	Office Visits/Consults	Yes		Yes
	Preventive Services (405 IAC 9-2-25), including immunizations, flu shots, annual physicals (including diagnostic services), pap smears, mammograms, routine prostate antigen tests, colorectal cancer	Yes		No

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS
Table 2. HIP Benefits

Service Category	Benefit	Reimbursable by MCO?	Limitations/Co-pay	Subject to POWER Account Deductible?
	exam/laboratory testing)			
	Smoking Cessation Services	Yes, with the exception of pharmacy services	Reimbursement is available for, at minimum, eight counseling sessions per rolling 12 months, and 24 weeks of pharmacotherapy treatment per rolling 12 months.	No
	Physical/Occupational/Speech Therapy	Yes	25 visit annual maximum for each therapy.	Yes
	Cardiovascular	Yes		Yes
	Radiology/Pathology	Yes		Yes
	Outpatient Mental Health/Substance Abuse (405 IAC 9-7-3)	Yes (self-referral)	Covered the same as physical illness.	Yes
Ancillary Services	Prescription Drug (405 IAC 9-7-6)	No		Yes
	Home Health/Home IV Therapy, including case management (405 IAC 9-7-2(a)(10))	Yes		Yes

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PROGRAM DESCRIPTIONS AND COVERED BENEFITS
Table 2. HIP Benefits

Service Category	Benefit	Reimbursable by MCO?	Limitations/Co-pay	Subject to POWER Account Deductible?
	Ambulance	Yes		Yes
	DME/Supplies/Prosthetics	Yes		Yes
	Hospice	Yes		Yes
	Comprehensive Disease Management (405 IAC 9-7-5)	Yes		Yes
	Family Planning (405 IAC 9-2-17)	Yes (self-referral)		Yes
	Lead Screening Services	Yes	19-20 years of age only	No
	Hearing Aids	Yes	19-20 years of age only	Yes